MEDICAL CLAIM FORM

City of Tempe Health Plan
TEM-9975

OBTAIN CLAIMS SUBMISSION INFORMATION FROM MEMBERS I.D. CARD

SUBMIT CLAIMS TO:
Arizona Foundation for Medical Care
P.O. Box 2909
Phoenix, AZ 85062

1. **Employee must submit fully completed claim form(s) as required by the Plan.**
2. **Bills** that are submitted for consideration **must be itemized and include: patient's name, diagnosis, date of service, provider's name, and charge.**
3. **If you or a dependent are covered by another Plan,** submit the bill to the primary Plan first. Send our office a copy of the Explanation of Benefits (EOB) and a copy of the itemized bill.
4. **If Medicare is the primary Plan,** submit both an itemized bill and the Explanation of Benefits (EOB) from Medicare.

Please remember, your failure to provide all of the information requested will result in the claim being delayed pending receipt of the information. If you need help in preparing your claim form or if you have any questions, please call The EPOCH Group, L.C.

EMPLOYEE DATA

EMPLOYEE NAME (FIRST, MIDDLE, LAST	SEX M ☐ F ☐	DATE OF BIRTH	
HOME ADDRESS	CITY, STATE, ZIP		COUNTY
EMPLOYER **City of Tempe**	OCCUPATION	HOME TELEPHONE	SPOUSE'S DATE OF BIRTH

PATIENT DATA

PATIENT'S NAME	PATIENT'S SEX M ☐ F ☐	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE

MARRIED? YES ☐ NO ☐ | FULL TIME STUDENT? YES ☐ NO ☐ | IF YES, HOW MANY CREDIT HOURS? _____

NAME & ADDRESS OF SCHOOL AND/OR EMPLOYER

NATURE OF ILLNESS | NAME, ADDRESS & PHONE NO. OF DOCTOR SEEN FOR THIS ILLNESS

IS THIS CLAIM BASED ON AN ACCIDENT? YES ☐ NO ☐ | IF YES, DATE _____ TIME _____ AM ☐ PM ☐ | DID THE ACCIDENT HAPPEN AT WORK? YES ☐ NO ☐

STATE HOW AND WHERE THE ACCIDENT OCCURRED

OTHER INSURANCE (INCLUDING MEDICARE)

ARE YOU OR DEPENDENTS COVERED BY ANY OTHER INSURANCE? YES ☐ NO ☐ | TYPE OF COVERAGE? SINGLE ☐ FAMILY ☐ | TYPE OF PLAN GROUP ☐ INDIVIDUAL ☐ MEDICARE ☐ OTHER ☐

INSURED'S NAME	DATE OF BIRTH	POLICY NUMBER	RELATIONSHIP TO PATIENT

NAME, ADDRESS & PHONE NUMBER OF SPOUSE'S EMPLOYER

NAME, ADDRESS & PHONE NUMBER OF OTHER CLAIM PAYMENT OFFICE

PLAN PROVIDES:
MEDICAL BENEFITS ☐ DENTAL BENEFITS ☐ VISION BENEFITS ☐ OTHER ☐ _____

If Payment Is To Be Made To Provider, Sign Below
AUTHORIZATION TO PAY BENEFITS TO PROVIDERS

I hereby authorize payment of benefits to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for these services. I understand that I am responsible for any charges not covered by this authorization

X _____ _____
COVERED PERSON DATE

Patient or Parent (if Minor) Must Sign Below
AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable by this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. A photocopy of this authorization shall be as valid as the original.

X _____ _____
PATIENT OR PARENT (IF MINOR) DATE